COMMONWEALTH OF MASSACHUSETTS ***DEPARTMENT OF PUBLIC HEALTH***

Clinical Laboratory Program

99 Chauncy Street, 2nd Floor, Boston, MA 02111

(617) 753-8439/8438 (617) 753-8240 - Fax

HEALTH PROMOTION SCREENING APPLICATION

I. APPLICATION INFORMATION

Name: _____

Address: _____
Street City State Zipcode

Telephone: _____ Contact Person: _____

CLIA #: _____ Certificate Type: _____

II. SCREENING PROGRAM INFORMATION

A.) Location type (check all that apply)

☐ Permanent/Fixed (complete section III) ☐ Temporary/Mobile (complete section IV)

B.) Facility or company which will provide final disposal of the holder's special medical waste:

Name: _____

Address: _____
Street City State Zipcode

Telephone: _____

C.) Licensed laboratory where specimens will be sent semi-annually to verify test accuracy:

Name: _____

Address: _____
Street City State Zipcode

Telephone: _____

CLIA #: _____ Certificate Type: _____

III. PERMANENT/FIXED SCREENING PROGRAM

A.) Location (address) of Screening Program

B.) Schedule of Operation

	Days of Week	Time (Hours)
_____	_____	_____
_____	_____	_____
_____	_____	_____

C.) Test procedure (check all that apply)

TEST	METHOD/ANALYZER
☐ CHOLESTEROL [Capillary Whole Blood]	_____
☐ ERYTHROCYTE PROTOPORPHYRIN [Capillary Whole Blood]	_____
☐ FECAL OCCULT BLOOD	_____
☐ HEMOGLOBIN [Capillary Whole Blood]	_____
☐ HEMATOCRIT [Capillary Whole Blood]	_____
☐ HDL CHOLESTEROL [Capillary Whole Blood]	_____
☐ GLUCOSE [Capillary Whole Blood]	_____
☐ PREGNANCY TEST, QUALITATIVE	_____

D.) Briefly state the purpose for offering the test(s) checked above.

_____

_____

_____

Signature of Authorized Individual _____

Title: _____

Date: _____

Telephone: _____

IV. TEMPORARY/MOBILE SCREENING PROGRAM

Please complete a separate application for each site where the screening program is offered and return to the above address at least 5 days prior to each screening event. PLEASE MAKE COPIES AS NECESSARY.

APPLICANT NAME: _____

A.) Location (address) of Screening Program

B.) Schedule of Operation

	Days of Week	Time (Hours)
_____	_____	_____
_____	_____	_____
_____	_____	_____

C.) Test procedure (check all that apply)

TEST	METHOD/ANALYZER
☐ CHOLESTEROL [Capillary Whole Blood]	_____
☐ ERYTHROCYTE PROTOPORPHYRIN [Capillary Whole Blood]	_____
☐ FECAL OCCULT BLOOD	_____
☐ HEMOGLOBIN [Capillary Whole Blood]	_____
☐ HEMATOCRIT [Capillary Whole Blood]	_____
☐ HDL CHOLESTEROL [Capillary Whole Blood]	_____
☐ GLUCOSE [Capillary Whole Blood]	_____
☐ PREGNANCY TEST, QUALITATIVE	_____

D.) Briefly state the purpose for offering the test(s) checked above.

_____

_____

_____

Signature of Authorized Individual _____

Title: _____

Date: _____

Telephone: _____